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ORIGINAL ARTICLE

Medical Educators' Perceptions and Experiences of Transgender Curriculum in Barbados

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Abstract

Purpose: This study explored medical educators' understanding of the term transgender and their attitudes and perspectives regarding (1) health system responsiveness to transgender needs and (2) transgender curriculum in medical education.

Methods: The study employed purposive sampling of medical educators responsible for design and delivery of curriculum. Fifteen of 18 eligible educators participated in Zoom focus groups (FG1 $n=7$, FG2 $n=8$). FGs averaged 93 min and were recorded, transcribed verbatim, and analyzed using a qualitative interpretivist methodology with deductive and inductive coding assisted by NVivo 12 Pro software.

Results: Educators were knowledgeable about the term transgender and the physical and psychosocial needs of transgender people. Participants viewed transgender care as a significant emerging health area. However, infrequent personal or clinical contact, coupled with constraints in human and other resources, resulted in the perception that transgender content as a stand-alone component of curriculum is difficult to justify. Participants articulated a need for broad-based diversity content, including disabilities, primarily at the undergraduate level. Educators saw transgender health as relevant for undergraduate-level psychiatry and postgraduate medical specializations. Analysis and discussion framed participant perspectives in the context of stigma, discrimination, and medicolegal and health systems that impede access to health care for transgender people.

Conclusion: Participants demonstrated knowledge of transgender and transgender health care needs. Areas for improvements in health care responsiveness were identified, particularly related to structural stigma and discrimination. Although participants expressed interest in including transgender health in the curriculum, this would require pragmatic optimization of teaching resources.

Keywords: attitudes; curriculum; medical educators; transgender; transgender health

Introduction

Transgender curriculum is lacking in medical education globally, and quality of existing curricula varies widely.[1,2] Gaps in transgender education exist at both undergraduate and postgraduate levels, including primary care, endocrinology, gynecology, urology, plastic surgery, and mental health.[3] These deficits contribute to health disparities for transgender people,[4,5] but evidence-based curriculum can enhance transgender-relevant knowledge, skills, and practice of trainees and providers.[3,6]

Few studies have addressed transgender care in medical education or practice in the Caribbean. Rambarran and Grenfell[7] identified deficits in knowledge, training, and experience supporting LGBTQ+ health care among primary care physicians in Barbados. Other studies included incidental coverage of transgender issues as part of homophobia and HIV-related stigma.[8–10] Increasing recognition of the unique needs and health disparities seen among transgender people motivated publication of Caribbean-specific guidelines,[11] including

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recommendations for research agendas and evidence-based curricula supporting transgender health. Following these recommendations, a recent study found that Caribbean medical students broadly endorsed the human value of transgender people but that their personal comfort and supportive beliefs regarding transgender were less consistent.[12] Attitudes and beliefs about transgender people are shaped by education and have important implications for empathetic and effective transgender care.

Because efforts to incorporate transgender health in medical education are influenced by the knowledge, perceptions, and experiences of faculty members,[3–6] research with educators is needed to understand barriers to and facilitators of effective transgender curriculum.[13] This study explored medical educators' understanding of transgender terminology and attitudes and perspectives regarding (1) health care system responsiveness to transgender needs and (2) transgender content in medical education.

Methods

We chose a qualitative methodology using focus groups (FGs) to generate descriptive data framed with an interpretivist stance, applying meaning to participants' in-depth accounts of their perceptions and experiences.[14–16] The University of the West Indies-Cave Hill/Barbados Ministry of Health and Wellness Institutional Review Board approved the study protocol before data collection (IRB No. 210210-A). All participants provided informed consent, and the study followed ethical principles of the 2013 Declaration of Helsinki.

Setting

Barbados is a Caribbean small island developing state with free tertiary education for nationals.[17] The University of the West Indies Faculty of Medical Sciences (FMS), accredited by the Caribbean Accreditation Authority for Education in Medicine and Other Health Professions (CAAM-HP),[18] began clinical teaching in Barbados in 1967 and expanded to the 5-year undergraduate MBBS in 2008. Medical education includes internship linked to the 519-bed Queen Elizabeth Hospital, the sole tertiary public hospital.[19] In addition, the FMS offers postgraduate training in general and orthopedic surgery; internal, family, and emergency medicine; and pediatrics and psychiatry. There are 37 full-time faculty members.

Sampling strategy and participants

The study employed purposive sampling. The research team sent e-mail invitations to faculty responsible for design and delivery of clinical training ($n = 18$). Faculty who agreed to participate attended one of two FGs conducted in March 2021. There were no incentives for participation.

Data collection

The multidisciplinary research team designed an FG guide informed by theories related to diffusion of innovation, and the construction of need in health and health care.[20,21] The FG guide explored knowledge of transgender terminology, health care responsiveness, information needs, and attitudes toward transgender in medical education. A medical educator who was neither a research team member nor FG participant provided pilot feedback on the guide.

FGs took place in March 2021 through Zoom due to COVID-19 restrictions. A female facilitator with training in qualitative research moderated both sessions. The facilitator had no prior personal relationship with participants. FGs averaged 93 min and were video recorded. The facilitator took field notes and debriefed with the lead analyst.

Analytical approach

An experienced transcriptionist produced verbatim transcripts. N.G. checked transcripts against audio recordings for accuracy and then shared with the second analyst (H.H.). To develop the coding dictionary, N.G. created deductive codes based on concepts informing the FG guide and developed additional codes inductively in collaboration with H.H. The final dictionary contained 17 unique definitions. N.G. and H.H. subsequently coded FGs independently using NVivo 12 Pro. The analysts discussed patterns of meaning emerging from codes and engaged broader research findings to discuss emerging constructs.

Results

Participants

Fifteen of 18 eligible clinical education coordinators participated in two FGs (FG1 $n = 7$ and FG2 $n = 8$). Educators ranged in experience from 1 year to more than two decades. Participants self-reported gender of male ($n = 7$) or female ($n = 6$); two participants did not indicate their gender (Table 1).

Table 1. Demographic Profile of Focus Group Participants

FG	M	F	Age range	Years involved in medical education
1[a]	2	3	39–53	7–21 (2 ≤ 10 and 1 ≥ 20)
2	5	3	41–59	1–27 (2 ≤ 10 and 2 ≥ 20)

N = 15 of 18 eligible educators participated. Of three nonparticipating educators, one gave a reason: time constraints.
[a]Demographic information declared by five of seven participants.
F, female; FG, focus group; M, male.

Emerging themes

Four organizational themes emerged from the FGs: (1) knowledge gaps, (2) tensions, (3) position and content, and (4) environment—stigma and discrimination. These themes informed the global theme of pragmatism. This reflects the idea that, although including transgender health in the medical curriculum is unavoidable, prioritization and implementation are challenging in view of perceived resource constraints and competing health care needs viewed as equally relevant. In the following paragraphs, we present the four organizational themes illustrated with exemplar quotes. Tables 2–4 summarize subthemes imbedded in the thematic framework for ease of reference.

Theme one: knowledge gaps. Although educators perceived the need to understand transgender health needs in greater depth, their expressions of need were not congruent with the general knowledge they displayed. In fact, participants were knowledgeable about the term transgender and displayed theoretical knowledge of physical and psychosocial health care needs of transgender people. Discussed needs related to (1) expected epidemiological risks associated with assigned sex at birth, (2) physiological health needs arising from processes needed to achieve physical appearance congruent with gender identity, and (3) stigma and discrimination experienced by transgender people (Table 2).

There is a possibility that the need for knowledge expressed by educators is, in fact, a "False Knowledge Gap" (FKG) related to the general knowledge needed to teach about transgender health care, but a "True Knowledge Gap" (TKG) related to specialist medical education and practice.

Furthermore, perceived lack of knowledge or inability to differentiate between an FKG and a TKG may cause educators to feel ill-equipped to deliver content they are capable of delivering, leading to Educational Inaction (Fig. 1) as seen in the exchanges hereunder (Table 3).

Theme two: tensions. Educational Inaction was further reinforced by educators' infrequent personal or clinical contact with transgender people and resource constraints in the educational setting, resulting in a deprioritization of transgender health care in the medical curriculum (Fig. 2). The quotes in Table 4 illustrate this.

These tensions contribute to perceptions that transgender health is difficult to justify as a stand-alone component of curriculum, but that content could be included in micro bites for undergraduates, with more

Table 2. Examples of Participants Showing Knowledge of Transgender Terminology or Elements of Health Care Needs

Theme	Subcomponent	Example quote
Knowledge gaps	Definition of transgender	"The only thing else I would add is that it, transgender is not cross dressing, am that's a different context and transgender does not equate to your sexual preference. As, as well am but I agree with everything else, identifying with a gender not your original biological birth gender as defined by your chromosomal or phenotypic appearance am; and it could be with or without an actual change of biological change of genitalia" (P12-FG2)
	Transgender health care needs	"Well, I would say similar needs to the population so depending on their original gender ah they still need things like screening for the cervical, the cervical cancer screenings, so am prostate screening although they might be originally male and then a transgender female, they might still have a prostate so still need a screening test. Mental health is a big issue so ah screening for mental health diseases 'cause they at risk for a lot of victimization and mental health issues like depression, anxiety disorders and so forth" (P10-FG2)
		"..if they are using mechanical methods to change their appearance and not surgical then the health needs might be related to those specific mechanical methods am like taping of the breasts,… and similar with male trying to hide their male genitalia so the physical presence of those things that you may take for granted …pressure sores and skin manifestations ….simple things like shaving and laser treatment for removal of hair …and other transplantations not only breast transplants but other kind of transplants, uh organs or otherwise that may be required." (P12-FG2)
		"I just wanted to add one thing to the medical elements, the hormones that P2 alluded to which would be the need for monitoring of metabolic things like liver function and kidney function and stuff because all these hormones could basically ya know damage liver function and those things, so they also need a lot of medical monitoring" (P1-FG1)

Table 3. Examples of Participants Describing Their Perceived Knowledge Gap and Feelings of Inadequacy Regarding Teaching Transgender Curriculum

Theme	Subcomponent	Example quote
Knowledge gaps	Perceived Knowledge gap	"I've actually managed one person who was trans male, … and of course I had no experience with it, so I ended up having to, to reach out to uh one of my mentors… like anything else, where it's not very common. In any specialty, we, we will not have the expertise." (P2-FG1)
		"because we're not exposed to it and that's not a regular part of our practice, we, we don't have the uh the information available, readily available as to specific health needs for example." (P5-FG2)
		"…it's something I would have to specifically go and seek outside of my normal specialty conferences." (P11-FG2)
	Education inaction	P8: "…you need a specialist to come in… and give the talk…cause certainly we are not that person."-
		MODERATOR: "Right so who should, who should this [transgender health] content be delivered by?"
		P13: "Not us."
		P11: "I-G-D-S." [Institute for Gender and Development Studies]

specific content for postgraduate training. This sentiment is discussed in the theme of position and curriculum content.

Theme three: position and curriculum content. Despite knowledge gaps and facilitators of Educational Inaction, participants displayed solution-oriented thinking: They perceived that transgender health education could be achieved, even in the context of constraints, if merged with broad-based learning objectives (e.g., human diversity) in undergraduate curriculum and postgraduate psychiatry, while being broadly applicable to other specialties at all levels.

> *Maybe we can start with education, medical, medical students and am promote more awareness. (P7-FG1)*

> *.. .there are these lectures they get in phase one. You know about health and disease and that, and that kind of thing where they get the general understanding of the inclusion of, everybody in health and disease." (P10-FG2)*

> *No, I think I'm in complete agreement it needs to be an undergrad something that's taught at the undergrad level. Am at the postgrad level I think it should be included in the psychiatry curriculum but not in any other curriculum. (P5-FG1)*

Theme four: environment of stigma and discrimination. Participants' perspectives occur in the context of stigma and discrimination that function as barriers to access of health services for transgender people, including distorted referral pathways, lack of recognition of gender, and unavailability of services.

Distorted referral pathways to care

> *I think anyone who encounters a patient that they think, or a patient reaches out to you and says that they are transgender or whatever that may be, I think that in the Caribbean we're still probably stuck in the situation where the first thing you'll probably do is refer this patient to a psychiatrist (P6-FG1).*

Lack of gender recognition

> *I think the greatest challenge is acceptance 'cause I'm not even sure if the legal framework or even if you're looking at the am hospital framework most of us do work in the hospital. So, if we have a patient come's in who identifies as transgender, so for example, I come in and I identify as a female, but I look like a male and I want to go on the female ward I'm not even sure if that is possible….Yeah, I think that's one of the main challenges that they would face not only in the healthcare setting but also in the general am, community because once you're assigned a sex at birth and it goes on your ID card. I'm not even sure if you can have that changed legally. (P9-FG2)*

Table 4. Examples of Participants Describing Factors That Facilitated Deprioritization of Transgender Health Care in the Medical Curriculum

Theme	Subcomponent	Example quote
Tensions	Infrequent personal or clinical contact	"…in Barbados because most persons are … like myself, I've never encountered um a transgender individual, but I've seen am some am … you know in the newspapers and so forth" (P3-FG1)
		"I don't know that it is (sighs) I don't know that it is a big enough area to necessarily have an expert in that particular area. And as I said, but that's no different to anything else, any other healthcare need that is very, very rare." (P2-FG1)
	Educational resources	P11: "There's a need for a person…they would fit into enough different programmes both undergrad and postgrad for it to be a fulltime job."
		P13: "But we can't hire any full time anybody now."
		P11: "I know 'cause we need to get, we need to get our permanent [name of medical discipline] posts before we get that transgender person."
		".. . behavioral sciences in phase one [first two and a half years of medical school] but beyond that I just don't think we have the resources really and I think you're remember you're dealing with UWI we are a very under resourced faculty. I think that has to be said, so may be somewhere else where there was plenty faculty yes but not here where we are so under resourced." (P2-FG-1)

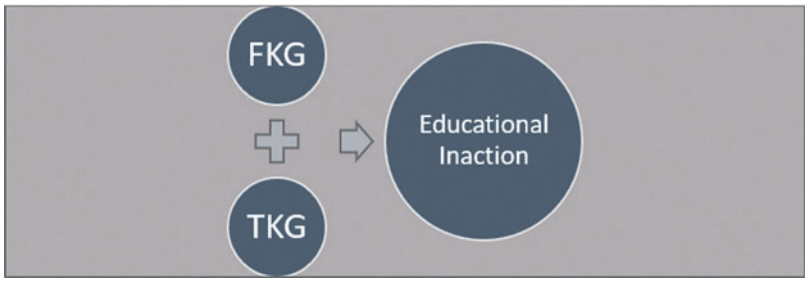

FIG. 1. Mechanisms for the origin of Educational Inaction. FKG, Fake Knowledge Gap; TKG, True Knowledge Gap.

Unavailability of health services

> *Right uh yeah, I think I agree with P13 um acceptance and obviously, am well P11 just made the point too about if you did want to have that full change, we can't afford it here. I mean there's no coverage and it's not done here so you would have to travel (PG8-FG2).*

Global theme: pragmatism. Following the issues articulated by participants, we theorize that educators took a pragmatic approach to framing the relevance, position, and likelihood of successfully incorporating transgender health in medical education. This pragmatic approach may be useful to facilitate human resource capacity building and incorporation of transgender health at several points in the FMS curriculum, despite perceived educational resource constraints and competing health care priorities (Fig. 3).

Discussion

This examination of medical educators' knowledge, attitudes, and perspectives regarding teaching and providing transgender health care in Barbados highlighted important deficiencies and identified four emerging themes that suggest recommendations for action. The global theme of pragmatism further points to practical strategies for training practitioners to provide competent and inclusive care.

Knowledge gaps

Educators described perceived (false) and actual knowledge gaps as barriers to including transgender issues in Barbadian medical curriculum. Owing to the actual knowledge gaps of educators and lack of confidence in the knowledge they do possess, faculty would benefit from continuing medical education in best practices for transgender care.[8,12,22] Specifically, there is a need for best practices in hormone therapy to be communicated and followed. United Caribbean Trans Network and Outright Action International's 2020 survey of 119 transgender people in the Caribbean found that, of 58 participants taking hormones, 71.6% indicated that they never do laboratory tests, despite 40% having obtained hormones from a doctor.[23,24]

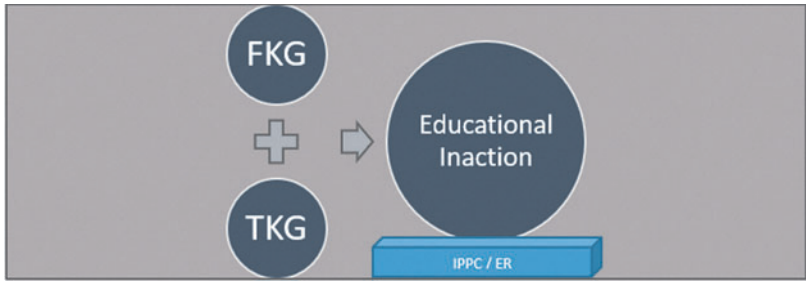

FIG. 2. Factors supporting Educational Inaction. IPPC, Infrequent Professional and Personal Contact; ER, Educational Resources.

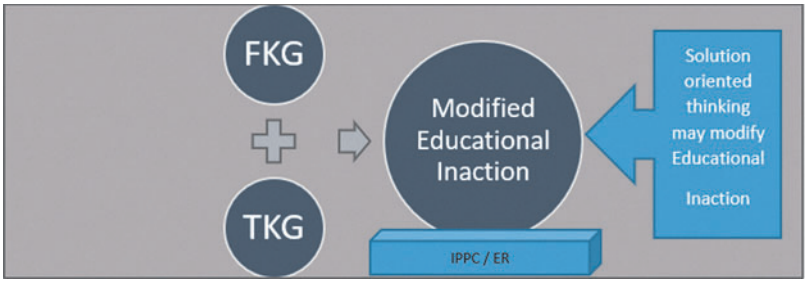

FIG. 3. Modifying Educational Inaction through solution-oriented thinking.

The finding that many transgender people in the Caribbean obtain hormones without medical guidance has disturbing implications for health. Furthermore, many who do obtain hormones from a medical provider are not monitored for potential adverse effects. These issues can be partially addressed through education.

Tensions

Educators reported some sources of tension as perceived barriers to their own educational action as well as to transgender-specific curriculum in Barbados. First, participants cited resource constraints. Second, lack of clinical or personal experience with transgender people contributed to the educators' lack of confidence. The lack of experience may be actual or perceived, given that transgender people may avoid disclosing their gender identity or avoid health care altogether if they anticipate discrimination.[24] Preliminary evidence suggests this dynamic occurs in the Caribbean.[23]

On the surface, educator concerns about lack of contact could be partially addressed by inviting members of the transgender community to participate in the continuing education of medical faculty, but forced and brief intergroup contact can create anxiety and further negative stereotypes.[25] To provide long-term, positive intergroup interactions that promote interpersonal comfort and acceptance, medical professionals need to create an environment in which transgender people are comfortable seeking health care and disclosing their gender identities. For this, providers must possess willingness and knowledge necessary to create practice environments explicitly welcoming to transgender people.

Position and curriculum content

Despite barriers, participants perceived that transgender-inclusive medical education could be achieved and displayed solution-oriented thinking regarding curriculum. The significance of this theme is not only the substance of educator suggestions, but their articulated belief that transgender-inclusive medical education in Barbados is possible and desirable.[8,12]

Environment of stigma and discrimination

Participants highlighted that the culture of medical care reflects a larger environment of stigma and discrimination[4] and theorized about barriers to health care that transgender people likely face, including inappropriate referral to psychiatry, lack of gender identity recognition, and unavailability of gender-affirming therapies and surgeries. These barriers arise from broader cultural attitudes. Medical education alone cannot remedy this,[3] and addressing transphobia directly is key.[26] Education for faculty, practitioners, and students should address inappropriate referrals and insufficient knowledge of gender-affirming treatments, as well as the broader context of transphobia.[3,7,24]

Pragmatism

The organizing themes revealed an emergent global thematic construct of pragmatic concerns contributing to exclusion or deprioritization of transgender issues in medical education. Addressing these concerns could remove some barriers to incorporating transgender health care into medical curricula and, ultimately, to quality transgender health care in Barbados.[7,8,12]

Limitations

Although the participation rate of eligible faculty members was 83%, this reflected a sample size of 15 faculty members at a single institution. We wish to note, however, that this is the only clinical training

program in medicine in Barbados and includes faculty and students from other Caribbean countries and directly influences medical systems in the Caribbean region.

Implications for research and practice

This study contributes to broader efforts to ensure that medical education is designed to meet the needs of all populations in keeping with the goals of universal health coverage. Although the relevance and effective implementation of transgender medical curriculum are emerging themes in literature from other regions (e.g., North America and Europe),[1–3,13] these topics have not received equivalent attention in the Caribbean.[7,12] Health-related issues of transgender people are complex, and the potential exposure to stigma and discrimination within the Caribbean has important implications for quality of care. To address these issues, clinicians must be knowledgeable and possess the requisite skill set to address the social, emotional, and physical health-related issues that clients may face.

Based on findings, we offer three practical recommendations. First, research and service audits are needed to identify specific indicators of structural stigma and discrimination in the health care setting. Second, resource limitations may be mitigated by partnering with international and community organizations, as well as interdisciplinary collaboration within the university. Dialogue among educators, health care providers, and the transgender community is key to generating effective real-world solutions. Finally, we recommend enhancing the quality of care through continuing medical education opportunities. The now-concluded Health Policy Project, which developed transgender health care training for Jamaican physicians, is a useful model.[27]

Conclusions

The current findings inform medical education in the Caribbean and may have relevance for other settings. Recruiting participants from a single institution with a relatively small faculty is a limitation of the study. Nonetheless, robust participant engagement and interdisciplinary expertise facilitated holistic exploration of transgender health curriculum in a context of limited resources. Findings provide a framework of thinking that may be useful in other settings. Understanding unmet needs for transgender health is not wholly sufficient to achieve inclusion and integration of transgender in medical curricula. However, recognition of unmet needs can facilitate solution-oriented planning for more inclusive education and practice.

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Authors' Contributions

Conceptualization, methodology, formal analysis, data curation, writing—original draft, writing—review and editing, visualization, and supervision by N.G. Conceptualization, project administration, writing—review and editing by M.K.E. and A.H. Formal analysis, data curation, writing—review and editing by H.H. Conceptualization, writing—original draft, writing—review and editing by J.G. Conceptualization, writing—reviewing and editing by A.A.M. Conceptualization, writing—original draft, writing—review and editing, and funding acquisition by M.H.C.

Availability of Data

The macro setting of this study has not been anonymized; consequently, there is a risk that some data, if made public, could lead to the identification of participants. Therefore, the data sets analyzed during this study are available from the corresponding author on reasonable request.

Author Disclosure Statement

No competing financial interests exist.

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Abbreviations Used

CAAM-HP = Caribbean Accreditation Authority for Education in Medicine and Other Health Professions
ER = Educational Resources
FG1 = focus groups
FKG = False Knowledge Gap
FMS = Faculty of Medical Sciences
IPPC = Infrequent Professional and Personal Contact
TKG = True Knowledge Gap